Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
G. PETER FOOX, MD

Respondent Name
SAFETY NATIONAL CASUALTY CORP

MFDR Tracking Number
M4-13-3148-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Rule 404.155 applies."

Amount in Dispute: $31.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The EOBs raise underlying issues of causal relation."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2013	CPT Code 99080 – Copies of Medical Records (33 pages)	$31.50	$16.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §404.155, effective June 15, 2007 outlines the cost for certain copies.
3. 28 Texas Administrative Code §134.120 titled *Reimbursement for Medical Documentation* effective May 2, 2006 sets out the fees for medical documentation
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16-Claim/service lacks information which is needed for adjudication.

Issues

Is the requestor entitled to reimbursement for copies of medical records sent to the Office of Injured Employee Counsel?

Findings

Based upon the submitted medical bills, the requestor billed CPT code 99080 – special reports or copies of reports, for 33 pages, on the disputed date of service. The requestor noted that the copies of medical records were for the Office of Injured Employee Counsel.

Texas Labor Code §404.155(a-b), states "(a) At the written request of an ombudsman designated under this subchapter who is assisting a specific injured employee, a health care provider shall provide copies of the injured employee's medical records to the ombudsman at no cost to the ombudsman or the office.

(b) The workers' compensation insurance carrier is liable to the health care provider for the cost of providing copies of the employee's medical records under this section. The insurance carrier may not deduct that cost from any benefit to which the employee is entitled."

Based upon the submitted documentation, the requestor complied with Texas Labor Code §404.155(a) and submitted 33 pages of medical records to the Office of Injured Employee Counsel; therefore, reimbursement for the copies of medical records is recommended.

28 Texas Administrative Code §134.120(f), states "The reimbursements for medical documentation are: (1) copies of medical documentation--$.50 per page." Therefore, 33 pages X $.50 = $16.50. The respondent paid $0.00. The difference between amount due and paid is $16.50.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $16.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $16.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/04/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.